STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

TRANSCRIPT OF PROCEEDINGS

STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
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REPORTED BY:
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APPEARANCES:

Alain C. Enthoven - Chairman

Dr. Phil Romero - Executive Director

Alice M. Singh - Deputy Director

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MR. ENTHOVEN: The Managed Health Care Improvement Task Force will now come to order. We'll begin with a greeting by Ms. Alice Singh of the announcement and purpose of the meeting.

MS. SINGH: Generally pursuant to AB 2343 Chapter 815 statutes of 1996, the Task Force has been charged with reviewing and reporting on the following aspects of managed care in California: The picture of health care service plans as it stands in California today including but not limited to the different types of health care service plans; how they are regulated; how they are structured; how they operate; the trends and changes in health care delivery and how these changes have affected health care economy, academic medical centers, and health professions education; whether the goals of managed care provided by health care plans are being satisfied including the goals of controlling costs and improving quality and access to care; a comparison of the affects of provider financial incentives of the delivery of health care and health care service plans, other managed care plans and fee for service settings, the effect of managed care on the patient-physician relationships, if any; the affect of other managed care plans on academic medical centers and health professions.

In addition, the Task Force will formulate and present recommendations regarding the regulation of managed care. These findings and recommendations will be published in a report due by January 1, 1998.

MR. ENTHOVEN: Thank you, Alice. I want to thank you all for coming. We have been visiting various cities around the state and hearing from the general public about their experiences, their thoughts about managed health care.

I would like to just say at the outset that what we are looking for are ideas and insights and specific suggestions for how we might recommend improvements in the system. We are interested in understanding better how its working and how it might be modified to be more generally satisfactory.

Also I would like to say that the public administration of the Medi-Cal program is not a part of our charter or focus. We are supposed to be looking at managed care and, of course, under the new Medi-Cal program more and more people are going into managed care. So the focus of our interest is how is it working for people once they are in managed care.

We have about a dozen people who sent up notes that they would like to speak. I would like to ask anyone who proposes to speak to fill out and send us a speaker's card and they're at the table back there and because of the number we're going to try to have to hold you pretty close to five minutes or so. So I would appreciate it if you would try to be fairly concise in your remarks.

We'll begin with Mr. Ray Ensher, health care for all California and consumer.

Mr. Ensher bravely sat through our whole business meeting this morning.

MR. ENSHER: Mr. Chairman and members of the Task Force, I really appreciate this morning's presentation. I became very much informed. I appreciate your enthusiasm and the quality of your discussion this morning. And, Mr. Chairman, I do have my remarks written for you and I will give you a copy at the conclusion.

MR. ENTHOVEN: Thank you.

MR. ENSHER: "The reforms we adopt must not only reduce costs and increase access to health care, they must also protect our rights as patients to make our own health care decisions. Effective health care reform must include provisions such as: reforms of our health care insurance laws, to make health insurance portable from job to job and to prevent insurance companies from excluding from coverage people with chronic health conditions; tax-free medical savings accounts, which individuals can use to pay routine medical expenses; malpractice reform; and administrative reforms, to standardize and simplify medical paperwork."

Now these are not my words but those of Congressman Radanovich of California's 19th Congressional District in a letter dated to me dated March 21st, 1995. Today many of these goals still have not been met and the human medical suffering, physically and financially, still exists. This may be a reason why at least five states presently are considering a single payer type of

initiative. As each day passes consumers are being more and more frustrated by HMO and administrative profits. We are in a medical crisis in this country and state for consumers.

Within the last few months a friend, 26 years of age with brain cancer, had to battle with his HMO to utilize the services of a surgeon in San Francisco. Needless to say he was turned down. This psychologically and physically was most draining for him. Where was the humane side to this decision?

In January of this year, I had a serious fall as a volunteer here in Fresno injuring my right side and shoulder. That cost presently is nearing $20,000. And I was told yesterday by my physician for the third time I'm going in into physical therapy starting today. What adds to that cost? X-ray after x-ray that I knew would be the same results, showing no changes, a rib belt costing 38 bucks that I can buy for 20. This was used in the dislocation at the emergency hospital, and this was put on me after my surgery. It should have been endless physical therapy, which I've mentioned twice which has run into thousands of dollars, and many of these charges are way out of line and with lower charges would still make a handsome profit for HMOs and lower consumer costs for insurance.

Upon the death of my mother in '87, I went over the medical charges and convinced the hospital of excessive charges including procedures not administered;

and the hospital eliminated over $2,000 on the bill. At that time a Tylenol was priced at $7.50. Unfortunately, consumers do not have the know-all, energy and the time of family crisis questions to question services and procedures, but we must hold our medical providers accountable. And this has been mentioned this morning along with the principals that were outlined for consumers.

I do not like to see state or federal governments having to regulate HMOs, but they have created a monster by excessive profits which does not serve the consumer in the human sense or financial sense.

Thank you.

MR. ENTHOVEN: Members of the Task Force have any questions?

Thank you very much.

DR. ROMERO: I have one, Mr. Chairman.

Sir, I would be interested to know has that excessive cost that you've described has that changed materially as you've shifted from fee for service hospital to managed care?

MR. ENSHER: No, I've had the knee surgery since I retired from teaching in 1990; I've had abdominal surgery which I was to go into gallbladder and ended up 30 days in the hospital with tubes down my throat and intravenous, which ran into another 40 or 50 thousand dollars. You know it's been one thing after another and I've seen this in all these surgeries.

As an educator I can do these things, but what about the common average person out there. And you did discuss this morning as far as consumers being more involved. I talked to my physician. I said I really don't want that procedure. I don't want to go through physical therapy again. I don't want to do these things. I know from my own body it's not working. And I tried to get a second opinion. Every physician that I tried to contact on the shoulder for a second opinion would not give me a second opinion. They said I cannot do it, whether it's liability or whether it's you've to be my patient and I'll do it, I'll take a look at you. It's a real frustration out there, but I haven't seen it get any better.

MR. ENTHOVEN: Thank you very much.

MR. HIEPLER: May I ask a question?

MR. ENTHOVEN: Yes.

MR. HIEPLER: What type of plan are you because it seems like you're describing --

MR. ENSHER: Blue Cross Prudent Buyer.

MR. HIEPLER: At any time did you have the opportunity -- because we deal with a lot of people who never do get services and it seems maybe you got more than you wanted.

MR. ENSHER: Mine is still through my school district but when I turn 65 I'm on my own. I don't have social security or Medicare. So I have to look on my own.

MR. HIEPLER: So part of your complaint is

you were overtreated at too high a cost?

MR. ENSHER: I think we all need to be aware and curtail these expenses as consumers. I mean I agree what was said this morning. I think consumers need to take more active interest in their own health care and ask questions that ought to be asked of their physicians and say I don't want that, that's not working for me. Why spend the money? Because, you know, it's an unselfish thing to do. I can say, well, my insurance is paying for that let all of you pay for it on your premiums, raise your premiums. That's a selfish thing to do. If we would stop and think that, you know, we have all this excessive stuff being done that it's costing every one of us more in premiums.

So as I say I may be a rarity and I know it's difficult for me to do that, but I don't want to be selfish.

MR. ENTHOVEN: Thank you very much, Mr. Ensher.

Next we have Jim and Anna Euless, patients at Kaiser Permanente.

MR. EULESS: Good afternoon. Those of you who are from out of town welcome to our Fresno weather.

I am a five-year survivor of a heart transplant plant done at Stanford University, excellent physicians, excellent follow-up, excellent control, and I even volunteered for experimental procedures. This was all done with the knowledge and blessing of Kaiser

Permanente. They set up the appointments, they paid the entire bill, and I can tell you right now after what they have put up with me since 1988, the surgery was in '92, and all the surgery and all the pills -- I've had 35 heart catheterizations and biopsies through the groin, there's so much scar tissue they can't do it any more. They have come up with approximately $850,000 for my benefit, approximately. The first weeks' pills when I left Stanford was $3400; not an eye was blinked.

In this, my continuing and managed care has been phenomenal. The first year I think I saw all three of my doctors. Dr. Anthrew (phonetic), my internist; Dr. John Wa Chan (phonetic), my cardiologist; and Dr. Susan Woodly who works out of the post and pre-transplant facility for Kaiser at Santa Theresa, which is south of San Jose.

I've also been referred back to Stanford several times especially when I went into a mild rejection twice. There was no thought at any time of backing down from their commitment, and this we need to bring to you that there are a lot of patients, we have five I believe here in Fresno Kaiser facility that have had transplants for hearts -- I believe I'm right on that -- and I know of at least 18 or 19 kidney, spleen, and liver transplants out of Kaiser. These, of course, were not done at Kaiser's facilities, they were done at Stanford primarily and U.C. San Francisco and U.C. Pacific. But the follow-up has been excellent. Just absolutely excellent.

I'm down now to where I see at least one of three doctors every month and blood tests are done every month.

So that is, in essence, what I have to say. My wife Anne would probably have a few things to say, she always does.

MR. ENTHOVEN: Mrs. Euless.

MRS. EULESS: What I would like to say is Jim had a heart problem beginning in 1971 over the course of the years between then and 1988 when he had -- or '82 when he had his four-way bypass surgery. We were under various different medical companies and I would suggest that by far the best treatment we've received from any of them is with Kaiser. There were no questions at all about the kind of care he was going to receive. He was under probably six to eight years of ongoing care with Kaiser physicians who worked in tandem to maintain his health until they could get him onto a list at Sanford, or attempt to anyway.

In 1992 when his condition had deteriorated so badly Dr. Chan made the suggestion we go to Stanford and try to get on the list. And in the course of our trips up there we were involved in an automobile accident which totaled our vehicle and put him into trauma and there was no hesitation whatsoever to take him in, not even bother waiting on the list he just got the first heart that came along five days after the accident. And as he said since then we've had ongoing treatment, there has never been a question about the cost of his

medication, his need to go in and see them. He's developed a couple of things that are normal side effects of the medication he's on, one of them is diabetes and they're keeping close tabs on that.

But we volunteer now. We have a premium that's being paid that we feel that we owe them more than that and we just like you to know we speak favorably for Kaiser.

MR. ENTHOVEN: Thank you very much for that. You know what we hear mostly are the complaints, the squeaky wheels, and sometimes I'm concerned that this all gets a little out of balance so it's wonderful for you to come and step forward.

MRS. EULESS: We do volunteer. And I will admit that on occasions you hear patients come in and say they don't like this doctor or that doctor, but the advantage of being under one roof like that is you can change doctors right there; you don't have to chase all over the countryside; you don't have to ask for a referral; you just say I would like to try somebody else and there you go.

MR. ENTHOVEN: Great. Any questions from members of the Task Force?

DR. ROMERO: One quick follow-up, Mr. Chairman.

I would like to echo his remark that your balance is very welcome; however, I'll invite you to be squeaky wheel on one subject. Has there ever been an

instance where you wanted to see a provider outside of Kaiser's network that you were either delayed from being permissioned to see or prevented from seeing?

MR. EULESS: Never at any time. As a matter of fact they made the contacts and got the doors open.

DR. ROMERO: They did it for you?

MR. EULESS: Yes.

MR. ENTHOVEN: They sent them to Stanford.

Tony.

MR. RODGERS: I was wondering, and this is really great that you've come forward. As you've used the system, what was it that you felt you needed before you chose Kaiser or did you choose Kaiser or was that given to you. Was there something that you did so that you could make a choice of a plan that would meet your needs? Did you know that Kaiser would do this for you or was there just this was a surprise once you got in, so to speak.

MR. EULESS: I'm a retired sergeant from San Quentin Prison, medically. I had a heart attack at age 39 that knocked me out of the system under the heart assumption bill. We came home to Fresno, after living in the Bay Area for a good many years. Our son stayed behind, he was a captain of Marin County Fire Department, you see him on the Golden Gate Bridge, he catches the jumpers. He joined Kaiser and he had a son that was hurt badly, but recoverable and very nice, I might say so, and I saw what they did for him. When my chance came in the open enrollment under the Public Employees Retirement

System I jumped to Kaiser back in '87 and have been with them ever since.

MR. ENTHOVEN: Barbara.

MS. DECKER: No.

MR. ENTHOVEN: Okay. Thank you very much.

The next presenter will be John Zweifler. I apologize if I didn't get your name right.

DR. ZWEIFLER: That was just right, thank you. I apologize for my voice being weaker than it should be.

By way of background I'm a physician. I'm a program director at a non-practice training program, I'm speaking on behalf of the California Physicians Alliance, and I would like to address issues related to managed care and how it impacts on myself as a provider.

The move to managed care has changed the paradigm from us as physicians 180 degrees --

THE REPORTER: Excuse me, you're going to have to slow down for me please.

DR. ZWEIFLER: Okay. From in the past where there were incentives to do more to a current system with under managed care with incentives to do less, and I don't think there's anything inherently wrong with managed care and we certainly need to do something to control health care costs.

Under our fee for service system there were some built in controls. Physicians were prohibited from referring to themselves through their labs or if they

owned a x-ray facility, they couldn't refer to those. There are some major differences between fee for service and managed care. In the fee for service system basically everyone was a winner. If we did more, if we had more health care related activities the physician profited, the health care plans profited, and the patients got what they want. So everyone was happy. Under managed care they are losers.

One big difference in the managed care system as a see it is there's an increased bureaucracy. If I was cynical I would think one of the objectives of managed care was to put various obstacles in the way of referring patients or getting treatment so that there's more places where you can make mistakes so that those particular referrals could be denied.

More fundamentally, though, and a greater concern to me is that I believe that managed care puts us as providers in a situation where we're adversarial with our patients, with out colleagues, and with the health care plans.

Now I would just like to illustrate with a few situations that have come up with me in the last few days in dealing with patients. I had one OB patient who is about 20 weeks, she came in, everything was going fine, her size was equivalent to dates but she wanted an ultrasound. I really didn't have any reason to order an ultrasound, but she wanted an ultrasound. So I'm in a position of either saying, sorry, you can't have that or

else ordering the ultrasound and having to argue with the health care plan or if I was in a strictly capitated system being in a position where it would hurt me financially. So I was put in a very difficult position in that situation.

Another example came up a child was brought in by their parents and they had gone to the emergency room because the child had fallen down and had been very upset and got up a minute later, had acted funny, and his hand became tense and fell backwards. As they were describing to me it sounded like the child had been hyperventilating, that was the most likely cause of the episode, but the family was quite concerned, and in the back of my mind was the possibility of a tumor or something else that might have caused it. And although I thought it was very unlikely and my first inclination was to not order it, the family was very concerned about it and so I ended up ordering that CT scan.

Now again that's a situation where it wasn't clear cut and where as in the past it would have been relatively easy decision, in this particular situation it became very difficult.

I saw another child the other day who had a history of surgeries and learning disorder. This is a child who is entered in the managed Medi-Cal program and for that reason had to have a primary care provider. This particular child was being followed by one of the neurologists here in town. The child's seizures were

actually quite stable, his last seizure was over a year ago, he was on single meditation Tegretol. So as a family physician, I really felt like I could have managed this patient, but this is an individual had a longstanding relationship with a specialist. So do I tell this patient no you can't see that specialist or do I make that referral. Again, I'm putting in an adversary relationship with my patients or with my colleagues. I ended up referring that one.

I had one other patient who had been followed by an allergist and was getting desensitization shots. And this particular individual seemed to be doing quite well and I couldn't really find any evidence of severe entofee (phonetic) in this particular individual. I just said, well, I don't think it's appropriate, why don't we try and take care of you and if we run into problems we'll refer you at that time.

My role as a physician has changed from the typical one of the past of being a patient advocate, helping the patient access the health care system, to being one who often is the gatekeeper, is the common phrase, and it puts you in a difficult position. I think it's an untenable position for us as physicians. We can't be focal for the entire system. You cannot put all of the weight, all of the decisions on the physicians and expect them to do it appropriately. I don't think it's fair.

I think that managed care has tremendous incentives to decrease utilization and these have to be

balanced with quality care concerns and health maintenance. I think this can be accomplished if physicians work collaboratively with health care plans to -- in utilization review it and quality insurance activities, but I think the goal of that should be not only to identify questionable practice patterns in physicians, but also so that we can try to eliminate some of the routine pre-authorizations so we can streamline the process and decrease much of the bureaucracy as possible.

I think it's incumbent on HMOs to very clearly inform and educate their parents regarding the limits to their benefits so that they're aware of what procedures are going to be required -- will require pre-authorizations; what things are physicians able to do on their own and what are they not able to do without authorization.

I would recommend as well that we monitor the ironically named medical loss ratio, the amount of money that is spent on health care as opposed to dollars coming in. The amount that is being siphoned out of our health care system right now is astronomic.

And finally regarding to managed care, I think managed care companies should be just as liable for poor outcomes as we as physicians are. If that was the case I think there would be much more concern about health care outcomes and quality of care as they are currently about decreasing costs.

I would also like to say a few words about

managed Medi-Cal. Most of the patients that I deal with are underserved. For my patients they actually have Medi-Cal, and that's good insurance and most of them have no insurance at all, I personally feel that our health care system in this country there's something rotten at the core when we have 40 to 50 million people uninsured and yet spend more on health care per person than any other country in the world. So I personally feel it needs a dramatic overhaul. I don't know that the answer is to throw more money at the problem.

One example that's being debated now is whether we should pay for a second day after vaginal deliveries. I'm not sure, as a person who has done a lot of OB, how much that's going to improve the quality of care in general, but again that's one of those situations where you end up in adversarial relationship with your patients.

As we move to managed Medi-Cal, I think it's important to recognize that Medi-Cal has traditionally been linked with indigent care. The way managed Medi-Cal has been implemented in this state is that it has been almost as if we've had blinders on. They're just looking at the Medi-Cal population and ignoring the traditional links that have been in place with indigent care; those links include disproportionate share of dollars to hospitals, cost reimbursement to federally qualified health centers, cost base reimbursement to rural health centers. These extra payments of health fund and support

the indigent and safety net that keeps our health care system afloat.

MR. ENTHOVEN: Doctor, in fairness to the people following after you I'm going to ask you summarize what's --

DR. ZWEIFLER: Let me quickly say about medical education. This is another traditionally area that's been traditionally linked with underserved populations.

Medical education has not been considered as we've moved into managed Medi-Cal. Medical education has traditionally been headquartered in county hospitals and traditionally cared for safety net for individuals without insurance. I think we should not only be facilitating our residents to learn about managed care, but we should actually be encouraging that by assigning patients in managed care systems to residents so they can learn how to practice in those kind of systems. That can be done by assigning patients who do not chose a specific provider, assigning them to safety net providers or to residency training sites, accrediting residency clinics as opposed to individual physicians to make it easier for residents to see patients in that regard, and also providing extra funds so that there's a level playing field so that the training costs, so that when patients are seen at training sites that training costs are covered as well.

MR. ENTHOVEN: Thank you very much.

Next we're going to hear from -- we have

questions.

DR. SPURLOCK: Thanks a lot for coming, I appreciate it.

I want to go back and use the examples you gave us. You gave the example of a disagreement over the use of an ultrasound sound in an OB patient. And on the disagreement, as I heard it, sounded like what it was necessary care from your perspective verses the patient's perspective. This is a common theme and we're seeing this tension between disagreeing whose going to determine what's necessary. If we take it out of your example and move it into the arena of physicians, one or more physicians disagreeing on what care is necessary, what do you think we should do as far as the mechanism to solve that? Ultimately we have to make a decision whether care is necessary; and what do you think would be the appropriate way for physicians who disagree on what would be the right answer for that process?

DR. ZWEIFLER: Well, I think that is where clinical protocol come into place and if you have quality insurance utilization review committee that include both representatives of the plans and providers, I think you can come to some agreement and understanding over some of these common situations. But I think equally important the patients must be aware of what the expectations are too.

MR. ENTHOVEN: Mark.

MR. HIEPLER: Of your capitated population,

can you give me an estimate, if there is any, of those patients that actually understand how you're paid or how the medical group is paid. Are there any?

DR. ZWEIFLER: I don't think any appreciate that.

MR. HIEPLER: One follow-up of the ultrasound and the CAT scan. Would it help you if you could say as a provider I don't believe this is medically necessary, however, outside of your plan you can go and pay for this yourself. Would that put you in a better position?

DR. ZWEIFLER: I can do that and the patient might not come back to me.

MR. ENTHOVEN: Michael.

DR. KARPF: As a medical educator myself, I would hope the position most educators would take is we don't need incentives that are against adequate care, we don't need incentives that are pushing more necessary care, what we need are incentives that push for appropriate levels of care. Appropriate levels of care means sometimes patient requests are going to be denied because patients expectations may not be in fact in line with what is appropriate for the problem at hand at that point in time. And I think that we have to be very careful that we not look back at the past and assume that just because we're allowed to do most anything we wanted and satisfy patients a bit more that those are in fact the best interests of the patients. As far as I know there is

no data that says the indemnity systems as existed in the past in fact had better outcomes or better effects on the patients. So there is that data and I would certainly like to see it.

DR. ZWEIFLER: I wouldn't argue that that was the case either. I mean we need to look to eliminate excesses. I think putting us in the position of being the bad guy, fall guy when we break that news is difficult and we should be partners in that with the health care plans.

DR. KARPF: Absolutely. But we want to share the responsibility of being certain we define what is appropriate and what's effective and what's not effective.

DR. ZWEIFLER: We should definitely be involved in that.

MR. ENTHOVEN: Steve.

MR. ZATKIN: Just a comment.

Doctor, I agree with your comments about the uninsured but I am not able to reconcile those with your view that everybody was a winner under fee for service because it's precisely the examples that you gave that resulted in excessive spending that did not enable us to have the money to cover the uninsured. Now we haven't covered them now either but at least now we have the potential to cover them.

DR. ZWEIFLER: That's a fair observation. I was being selfish in that regard. I think I was thinking of myself as a physician and health care plans and the

people -- the health care system profited everyone in the health care profited. Our society did not necessarily --

MS. DECKER: And the employers didn't.

MR. ENTHOVEN: We're going to have move on. I feel terrible about cutting these short but in fairness to the many people who've indicated they want to speak we're going to have to try for five minutes.

Next person is Don Albright. Mr. Albright.

MR. ALBRIGHT: I'm Don Albright, I'm a consumer of health services and I'm also a member of the local health care coalition.

As a consumer in the past 15 years I have had, myself and my family, major medical expenses which I would have to pay resulting perhaps in a few hundreds of thousands of dollars. As a retired state employee, however, I perhaps have the best coverage that's available for health care any place. I have Medicare and, of course, PERS care. I wish that all seniors, in fact all citizens of California had the same coverage that I have. I think we would have a much better situation.

Also I have, I think, been an observer of the health care scene for the past ten years or more, and one of the interesting things to me is that some of the arguments used to defeat single payer here in California and other good policies are legislation at the national level are arguments that now are criticism against health care, health management organizations. The same arguments namely that it would destroy -- that the HMOs destroy

physician-patient trust, that administrative -- if we had a government plan the administrative cost would go out of reason; and that certainly with the plan more or less under the auspices of the government the quality of care would suffer and then there are others. This is the most interesting situation.

I think also I recognize that managed care has emerged really as what our national policy is for health care not as a result of any deep continuous study, but more or less with conditions pretty much for the most part ignored by state and local legislation.

I am encouraged that there is a body such as this who is making what I'm sure will be a comprehensive study of what is happening, and I would hope that one of your recommendations would be for a continuous comprehensive study until there is apparently there is one of the best health care situations in California that is possible.

Thank you.

MR. ENTHOVEN: Thank you.

Next speaker will be Mr. Jeff Reed. Is Mr. Reed here?

MR. REED: Good afternoon. First of all I have a both an official and unofficial capacity. I'm the city manager for the city of Fresno. First of all, I would like to, on behalf of Mayor Patterson and the entire council, welcome you all to the city of Fresno. With that let me also say I am here as an individual. Anything I

have to say is going to just be my own personal thoughts and reflections.

I know that what I'm going to talk about is not necessarily the focus of some of the reforms that your commission can necessarily sponsor or achieve because I'm going to talk about federal tax policies and how I think they're a solution to the problem, but I do think in light of the fact that managed care is such an important component of California's health care system that your commission report is going to have some great benefits throughout the nation. So I would like to consider addressing this aspect because I think it holds a great part of the -- not only the -- I think a description about the source of some of the problems but the potential solutions. And I'm not a great policy walk in this field and I don't pretend to be.

Most of my discussions are going to be general terms and broad generalities and not based on personal experiences, but I want you to know I've had a little bit more involvement, I think, than the average citizen in the issues that you're dealing with. I used to serve as deputy secretary and general counsel for the Business Transportation and Housing Agency, and so we oversaw the Department of Corporations and later served as the undersecretary for Govern Wilson in that agency. I saw firsthand the lobbying efforts, the amount of money, if you're going to change the semicolon or comma in any kind of legislation. I understand the stakes that are

involved in this field.

Employer provided health care benefits is an accident of the Tax Code because when they first wrote the Income Tax Code they didn't address it and so many people didn't think it was taxable as income and so they began the pattern and practice of having the employer provide in order to avoid the taxability. Later the IRS decided that wasn't what they had intend, by then such great coalition of support had been built up that they were never able to maintain that position so it ultimately became adopted.

What that did was it separated the consumer of health care from the buyer, fundamentally, and it therefore did not allow the price mechanism to work, which is an important component in our society in how we allocate scarce resources. I would argue the price mechanism is a truism of economic principals and societies who ignore it or try to come up with substitutes for it end up being fairly inefficient and not successful in the long term.

What it caused originally through to the indemnity plan provided through the employers was an overconsumption, which led among other reasons to price escalations, and I know there's a lot of other explanations for price escalation. But you disconnected the consumer from getting involved and checking and asking questions and fundamentally making choices based on the price mechanism. So we began to attempt to solve the problem by creating gatekeepers and other devices but

they're still not adequate substitutes for the price mechanism.

And so what we have done is we have created the gaps between the physicians and the patients where we try to make them gatekeepers and overconsumption that's caused by indemnity plan. We try to create gatekeepers to try to drive the overconsumption, and fundamentally the price mechanism is still not being permitted to work and allocate scarce resources in an efficient manner.

The solution is to reconnect the consumer with the purchaser. It solves both problems of pricing, affordability, accountability. And how do you do this? You go back to the Tax Code. You allow full deductibility to the individual for all of their expenses for health care including premiums paid for insurance products and medical savings accounts -- to the extent that they come up with different mechanisms and strategies for their own health care purchasing needs -- and what this will mean to the extent that HMOs remain, and I think they can be in a competitive environment like that, it's still a viable mechanism for health care delivery. But it means all this information that we're talking about developing on behalf of the consumers about which health care maintenance organization program provides the best level and quality of services and coverage and treatments will actually be meaningful to them because they can make a choice.

When I was at the state we had great choices among competing health care maintenance organizations and

PPOs and indemnity plans, and as a state employee we had great choices and the information that was being provided was helpful. But when I was in the private sector as an attorney and now with the city of Fresno I only got one choice. I got one plan. So all the wonderful information you develop may be of a benefit for the employer, but it's not going to help the consumer make choices among them because for the most part the employer is the decision maker not the consumer.

MR. ENTHOVEN: Mr. Reed, I have a recommendation for you. When you go back to work, that is for Fresno to join CalPERS, which you certainly can do.

MR. REED: I don't know that we can afford it, sir.

MR. ENTHOVEN: On the contrary it's a very good deal. I'm shocked you haven't brought Fresno into CalPERS, then you would have multiple choice of plans?

MR. REED: Frankly, if I had all the decisions and the ability to make decisions we probably would be. We do have a separate health care trust plan that has free management employees and free union employees and they make those decisions. Fundamentally, their prices for the coverage are in the $300 ranges for individual families and stuff.

But anyway I guess the point I want to make is I think that the Tax Code is the solution and then you can allow prices to drive the decisions and create appropriate allocations of scarce resources. If you

decide you need public subsidies for those individuals who otherwise couldn't purchase it, then you can provide those public subsidies but you can do it knowing how much it costs directly rather than through other substitutes.

MR. ENTHOVEN: Peter.

MR. LEE: Are you saying that would solve it all? Because I think in any economic theory where there's dissymmetries in information, different bargaining positions this is not like buying a car with Consumer Reports. Consumers are never going to have the same level information and your tax point is well taken but that's it? Is that really it or do you think anything else is needed to have a level playing field?

MR. REED: I think it's a pretty good start and I think information is a pretty free commodity and it's becoming more freer and accessible; and I think that prices become substitutes for people who can't make choices, who don't get the full information. Those who do market, you know, you assume efficient markets people who will make the effort will make the decision that will drive the prices; and those of us who may not have the time and effort to make those choices in many ways have the price that are determined by the market to be a substitute for what's a more high quality coveraged care and greater levels of coverage and those maybe lower scale types of coverage issues. But we can make choices among ourselves too about the physicians and we don't have any of that information right now about the physicians. And

so it won't be anywhere worse off with regard to physician choices which is I think is the true desire of the individuals is to know about the quality of their physician and the information that they're providing to their physician and when they believe that their physician is trying to control their consumption for economic purposes, they no longer have confidence in the information that's being provided by their own physician.

MR. ENTHOVEN: Bud.

DR. ALPERT: I would simply submit to appreciate your time and what you're suggesting here and verifying that is that the same way Dr. Karpf pointed out that incentives that produce proper quality and proper practice all other incremental devices that allow mechanism to click to put people back in touch with it.

The purpose as towards the disconnection we aren't going to get rid of the third parties. It's not like buying groceries, having a third party buy your groceries because there's nothing in the supermarket that cost a half million dollars. Heart transplant, the technology is simply that expensive. We need -- if we come up with incremental contributions that are productive and cost effective and produce goodwill and good faith those are the things we may in retrospect find most valuable and this maybe one suggestion.

DR. ROMERO: A quick comment to pick up on the last few themes.

I don't think -- I may have been

misinterpreting but I don't think you would suggest that full deductibility of health costs is the only thing that the Task Force should do. It's a start.

MR. REED: I understand it's outside the realm of what you can achieve and I think there are some other areas you can focus on and I think understanding an efficient process for resolving disputes between -- there are two different types of disputes that will come up, one will be the coverage issue and the other will be the quality of the proposed prescription and everything. I think you need to have efficient mechanisms for resolving two separate --

DR. ROMERO: Something for the Task Force to put in you mind and think about. This is outside of the implied scope of our discussions heretofore because as Mr. Reed said at the beginning it's first and foremost a federal tax issue. For your consideration something we need to decide in the next couple months is whether we would at least like to make a statement along the lines of Mr. Reed's suggestion, which we could elaborate for state tax law. That's not a suggestion, that's something to agree and think about.

MR. REED: I think that's effectively what I was suggesting.

DR. KARPF: Mr. Reed, discuss with me how in terms of tax law but I'm not sure that goes into the essence. I think I hear -- what you're saying is just like we're asking for accountability on the part of

physicians, are we asking for accountability on the part of the payer? We have to expect some accountability on the part of the consumer so there can't be that disconnect across the board.

MR. REED: By making them the buyer I think you give them the incentive to be engaged --

DR. KARPF: There has to be some assurances, which what we don't need in this country is where a lot of young people opt out because they think nothing is going to happen and don't participate in the process. So you do need some things that will balance the system. The accountability I think is good across the board.

MR. ENTHOVEN: Clark.

MR. KERR: You seem to indicate that choices are important to consumers. Were you indicating that health plan level information alone is not enough that it should be filled out at physician, hospital that level?

MR. REED: I think so. I think to make information meaningful to the individual if we're going to engage them in there I think they need to have choices among physicians.

I think quite frankly that -- well, when I was at the state level and I had choices among plans, the choices are driven by, well, which doctor should I have and is that doctor covered by the plan. I think that's how most people end up picking their plan is by whether or not it includes the doctor that he want to see.

MR. ENTHOVEN: Thank you very much.

Next Barbara Lundeen, Ph.D.

DR. LUNDEEN: Mr. Chairman and members of the Managed Care Task Force, I'm Dr. Barbara Lundeen, I'm semi-retired health educator and I'm here to testify on my own behalf.

I'm involved with several senior organizations such as ARP Votes, ARP Health Advocacy, Congress for California Senior, California Retired Teachers Association, and Fresno/Madera area agency on aging.

I have worked for 25 years among seniors. Presently, I'm one as well and I'm also involved in two HMO -- been involved in two HMOs. Hopefully I can also represent Fresno seniors as I did as a delegate to the White House Conference on Aging.

After reading the Fresno Bee article this morning, I decided to change my testimony rather drastically. It says "forum speaker say health care revolution is here." Did anybody see it?

Well, you want to know what is the problem? For the first time we seem to have an organization, the HMOs, that would benefit by keeping people well and what are they doing about it? Number one, as the article mentions prevention. Number two, as the White House Conference on Aging mentioned -- and this is how the resolutions were summarized if anybody wants to read them. It's worth reading because we really worked hard at it -- according to the White House Conference on Aging we need a

comprehensive wellness system that would empower seniors and others to assume personal responsibility for the state of their health. A system that would focus on preserving and restoring natural harmony of the individual while using natural means whenever possible while aiming towards the total well-being. A system including different factors involving optimal well-being and their interrelationship such as the mind-body interconnection that's hopefully dealing with the causes.

Actually a system leading to true health reforms has already been proposed by Health Education and Welfare Department in 1981 in the health policy paper. Of course, then anyone that was a health educator was sabotaging the system because the system depended on the -- the sicker they were the more money they were making.

Number two, the use of alternative methods as you probably are aware the journal for -- The New England Journal of Medicine according to a survey one out of three Americans today are using alternative methods. And some of the insurance companies are now including it as long as they are safe and cost effective, why not.

It is also clear anybody that has been reading books by Andre Vail (phonetic), he has been in Fresno, he's from Arizona, he's nationally known and he makes it very clear some of the problems we are facing as we get older our present traditional methods do not work. There's also a question what is traditional and what is

nontraditional. Because we're finding out what they call alternative is really more traditional than our present system. So those are some of the questions to ask.

Yesterday afternoon I was gladly surprised to get a phone call by somebody by name of Dr. Edward Show (phonetic) who's the author of a book "Miracle Healing from China." She's now internationally known; she works with the Canadian government. She has been in Fresno about 20 years ago but not since but still she seems to be very well known.

This is an excellent book that the Canadian government is very much interested in. By the way, the Canadian government -- talking about -- Dr. Albright mentioned the single payer system, but you have one government that talks about health education, how to reach out in the community, and so they are two handbooks available, and I have a family still living in Canada, I'm a former Canadian and you know it's much simpler to do a mass education program when you have single unit behind it which we don't have now. The individual HMOs are doing a program here program there but not a comprehensive program. So there are other ways we can save money too and that is teaching people self-care, okay.

What are the solutions? Obviously, as I mentioned you would have to have a single payer system instead of -- since we don't have maybe we need a task force, a state task force to stop people in the field that

could look at some of the materials and see what we can do.

How do you pay for the project? Years ago when I was in Sacramento on a task force it was felt that maybe we should take a certain percentages, like one-tenth of one percent of the public funds we spent on sickness care and allow that money for preventive care so we have some money with which we could work and hopefully get something accomplished.

As an educator, I feel a tremendous opportunity in education. Because through education we can reach the mass population using mass media and so on. Rather than today where we still concentrate on one-to-one approach. So the person has diabetes and the doctor has to spend time one-to-one, very difficult. I think we need to start looking at mass education.

In closing, I would like to make some very, very quick comments. I understand that here in Fresno County we are receiving lowest rate reimbursement in the state for Medicare clients; number two, there's a bill coming out that would help the physician that talked before which would give doctors more authority in deciding matters of the treatment contested by the insurer and it's a bill sponsored by Assemblyman Figueroa.

Then there's a bill that concerns me, need a bill that would reimburse HMO by the previous HMO which was negligent in detecting and treating a medical problem. This has happened to us, several of us, like skin cancer

overlooked and by the time we went to the second HMO it was a costly surgery.

And those of you that are not doctors, what they do now is they can come with a spray gun and spray liquid nitrogen, bang, bang, bang, on any spots that look cancerous. But if they're overlooked for a couple of years you can see how the expense is.

So I think in closing I would like to express my gratitude to the members of the Managed Care Task Force for coming to Fresno and giving us opportunity to speak up with the hope that the system could be improved. I would like to thank you.

MR. ENTHOVEN: Thank you very much.

Next we have Reverend Walt Parry, local health care coalition and Fresno Metro Ministry. Welcome, Reverend Parry.

REV. PARRY: Thank you very much.

The first portion will be on behalf of the local health care coalition and the second portion will be personal.

I include for the record the more detailed statement of the local health care coalition regarding how two HMO managed care Medi-Cal is about to dismantle our health care safety net and is threatening our total health care system.

A flawed enrollment process, we believe, and not patient choice has caused beneficiaries to abandoned the traditional safety net providers. Late payments and

low payments from the two plans further jeopardizes the safety net. There is no overall accountability for what is happening here. Facility fees previously paid under Medi-Cal help providers build capability for all their services including Medi-Cal and indigent care.

As a result of the state imposed managed care system and our county's inability to come up with a workable local initiative, our health care system is being badly damaged. Many of our health care delivery systems are directly or indirectly linked with the teaching programs of the University of California San Francisco and others. University Medical Center is totally dependent upon that teaching program, and the health delivery resources of that program, as well utilized also by rural clinics, Valley Children's Hospital, Fresno Community Hospital and others.

We are a high poverty county, poor public transportation, geographically isolated, and the state has imposed a structure which can cause us to lose the only level one trauma center that we have here between Los Angeles and San Francisco which is at University Medical Center as well as lose the services of many of the rural clinics and other traditional safety net providers.

Medi-Cal revenues have been used to build capability for other needed services and this should continue. The system must be put on hold, the system of the two HMO managed care Medi-Cal, until we find some way to save the safety net and the whole health delivery

structure in this county. Government's role is to protect the public and not to endanger it.

My personal comments. In a time of scarce resources for some, far too much of the dollar paid for medical care has been diverted from delivery of health services to profits for insurance companies who employ persons to override the medical decisions of providers and the choice of patients. Most patients have little choice as to who their provider will be, and often are bounced from one provider to another as their company changes plans or various doctor groups realign with various hospitals and other entities.

Patients know that their primary care physician is under great pressure from the insurance company to not refer to a specialist. The patient is left out of most of the choices and the doctor is left out of many of the choices in a market driven rather than medical driven system.

For two years my personal insurance was through Cigna. In opposition to what my daughter's surgeon said was absolutely necessary for follow-up physical therapy after an emergency arm operation, Cigna overruled the doctor and my daughter. Cigna refused also to pay claims for long periods of time saying that they were unauthorized such as when the metal plates that had to be removed from my daughter's arm from the previous surgery took place. They said, well that wasn't authorized. So I guess you're supposed to go through life

with the metal plates and screws there. It took Cigna over a year to pay several of my daughter's bills even though phone call after phone call resulted in their saying they would take care of it. They delayed payment time after time questioning whether the service was authorized, whether my daughter was actually in school, and whether my daughter's on-campus clinic was her primary insurance.

Also when she went back for the follow-up with the surgeon that did the emergency surgery on her arm they said that was unauthorized.

Patients are denied choice and service. Provider's medical opinions are often overridden by distant insurance employees. Money that should be going for health care is going for insurance profits. It is not a good system as practiced.

In conclusion, to go back to my first part is that because of our high poverty, because we do not have a local initiative, and because of the many problems of both slow payments, low payments, not paying facility fees, our whole delivery system in this county, which is intertwined with the teaching program, is in major jeopardy. And again our trauma center took over the Board's University Medical Center to go by the boards. Of all these services that were interrelated one with another are dependent upon the revenue that comes from Medi-Cal services.

And, again, we believe that it's faulty

enrollment process, wrong languages, not knowing -- not listing the providers that the people would know the name of the residence or the name of the facility where they go for their services. We feel that it is not patient choice that drove people from the safety net but this confusion.

Even if it were patient choice, the state and the county, as well as other citizen here, have to find some way to maintain our health delivery system and particularly the safety net system. Within the city of Fresno 47 percent of children in youth under age 18 live at the poverty level or below. For the county it's 37 percent. But, again, we have high poverty, high need, and regardless of whether it's faulty enrollment, which I believe it was, or patient choice, usually choice happens when people know what they're choosing between. But for either of those we have to find a way to maintain the health delivery system of this community that also provides services to those persons that are officially medically indigent, but also to those persons who do not qualify for the medically indigent program but who have no money for their care.

So it is I think at a crisis state in this community and we request your help and your understanding of what we're facing here.

Thank you.

MR. ENTHOVEN: Thank you.

Are there any questions or comments? Thank you very much.

MS. BELSHE': Reverend Parry, I think you're bringing up a good overview of some of the challenges we're facing here Fresno and Fresno is unique, as the Reverend indicated, it is one county where the county was unable to come together in terms of creating a local initiative and as a result thereto commercial plans operating as part of the managed care effort, and certainly the Department and others will acknowledge there are real challenges we face in Fresno as we do in other counties.

One of the things we have done in Fresno what's somewhat unique is we created something called red teams that brings -- includes representatives of Department of Health Services, the enrolling contractor Maximus (phonetic), Blue Cross Foundation, which are the two commercial plans here. The providers most notably the major provider community group consumers and so on. To sort through many of the issues that you've identified in a more corroborative and productive way would be enrollment, reimbursement, authorization, safety net facility, etc. Question one, Reverend Parry, have you participated in red team discussions and if so what's your sense of how they're progressing?

REV. PARRY: Yes. I'm probably the only consumer type that is on that team. There may be some others; it's primarily providers. And I commended the state, the two plans and the providers for this effort. What that group has been successful at is dealing --

somewhat successful -- is dealing with some of the day-to-day operational problems and many of those problems have been resolved through that process, and I commended everyone for that.

However, there's some major problems that have not -- facility fee, things of that sort, and generally the more systemic problems are not really being dealt with. And some of our health care entities are this close to going under in reality and cannot take too much more of the stress. And with the people abandoning the traditional safety net providers through this process there is nothing being done to my knowledge at this point of how we as a community can maintain basically our health care system, particularly with the safety net aspect of it.

So the red team has been very good in solving most but not all of the operational problems. And some people here who -- the chairperson of the red team is here and I hope will speak in a few minutes and she can respond to that as to really what she feels has been the major success and what yet has not been able to happen.

MS. BELSHE': Follow-up question. I think one of the mechanisms that folks spoke to a couple months ago to try to deal or create a forum for discussing and addressing some of those systemic issues was the idea of creating a Fresno County Managed Care Commission, much like we did in Sacramento that proved to be very effective model. Have you provided input to the county board and do

you have any sense of the board's moving forward with that idea?

REV. PARRY: Our recommendation that had gone to the state through a variety of people was that we have a Fresno County Medi-Cal Commission, since we are unique not having a local initiative and again the high poverty, the high need, but from our perspective it had to have the state direct involvement in that and that the state had to be a major participant; that the plans had to be involved, the county representatives had to be involved, the providers had to be involved, and people representing beneficiaries and citizens had to be involved. And initially it is our understanding that the state said we can do that.

Then the state, according to my information, said specifically no the state will not be involved, that you as a county can create a county commission and then if that commission wants to talk with us we will talk with that commission but we will not be a part of the commission. And what we read into it is that the state felt the direct participation might violate the contracts they have with the two plans. And our thought is that for that commission to be effective which needs to monitor and to be able to have information accessible in order to monitor and then to be able to find ways to correct the major problems that exist, that the state had to be a direct participant. So I think if the state at any point says they will be a direct participant in that commission

and that the commission can have access to some of the material which we would need -- that the commission would need and to work together that would be very helpful.

MS. BELSHE': I appreciate your response that's why discussions like these are helpful you're hearing from me the state does want to be involved. We have every intention of being involved. We are looking though to the Sacramento County as a pretty good model. We're looking to the county here in Fresno to make the appointments in terms of moving it forward but we want to be a party to the meetings in a very formal and structured way.

Clearly the commission can only go so far unless the state is direct participants, so indeed we do want to participate.

REV. PARRY: I'm glad. I have not seen the Sacramento model. We were informed though as late as last week that the state would not be a direct participant in that commission. And if you're saying that at this point the state will be, I think we welcome that and that could be an arena through which we can get to some of the these major issues.

MS. BELSHE': And it may be just a question of semantics.

MR. ENTHOVEN: One more question, Michael.

DR. KARPF: It's not a question it's a comment. I don't think anyone should leave this room thinking that the danger to the safety net infrastructure

in Fresno is secondary transition to managed care Medi-Cal is a local problem. It has broader roots than that. It is a fundamental problem at U.C. Irvine where there's been patients away as Medi-Cal patients become -- especially young women become more attracted to the private sector. It will be a problem in Los Angeles where County Hospital and potentially for multiple pediatric facilities. So there's structural issues involved there. It's not a local enrollment problem I don't think.

REV. PARRY: We are well aware of the problems that all the counties are having, but what makes us unique, two aspects, is with our own accounting in this plan that does not have a local initiative that has the capability of helping. --

DR. KARPF: Even though those counties that do have local initiatives, that's not sufficient protection for the safety net hospitals to keep them from getting into trouble. So I think there's more to it.

REV. PARRY: I think there's a problem with the system all over.

The other thing though for Fresno County is compared to many places our poverty level is far higher, unemployment stays around 15, 16 percent, parts of our community would have an unemployment rate of 40, 50 percent.

MR. ENTHOVEN: Thank you very much.

I just do want to repeat what I said earlier is our assignment and focus is on managed care as such and

so the specific questions of the state's management of Medi-Cal program aren't really within our charter, although these are interesting and important questions.

Next I would like to call on Mr. Bo Carter of Integrated Health Care Associations.

THE REPORTER: Excuse me, Mr. Carter, I need to change paper please.

MR. ENTHOVEN: Okay. We're back on the record.

MR. CARTER: Thank you, Mr. Chairman.

My name is Bo Carter, I'm executive director for the Integrated Health Care Association. It is a 32 member statewide board composed of HMOs, medical groups, health care systems, couple of hospitals, an academic, a business purchaser and consumer. So we are in some respects the mirror of the kinds of perspectives that exist on this Task Force, and in fact a number of our organizations are represented on your group.

I appreciate the chance to have some time this morning with Ellen Severoni to talk about our consumer feedback interests so I won't duplicate that and I will try very hard not to go beyond five minutes because I know you're getting late and there are people behind me.

I wanted to mention a couple of things that my board is interested in and may be of some use to you and what I will do is follow that with some material that at this point I will send just to the chair and staff director and you two in your sole discretion can decide

what more paper the members of your Task Force can stomach.

We've done some work on graduate medical education and it's disconnect between what we think a managed care market place needs and what the health care education system is producing both in physician and non-physician work force, and that may be of some interest to you as you look at the impact of managed care on academical medical centers and GME.

You've heard about consumer feedback models. We're just completing a project where a group of practicing physicians, we sat them down and discussed whether there was a need for a new set of medical ethics given managed care. I know you have and will continue to hear about difficult pressures that physicians in different kinds of practice settings with different kinds of compensation arrangements have, and I'm happy to share at least the draft report. The group is still writing its final version which may have some interest both in their perspectives and the project that we just agreed to attach ourselves to yesterday looking at a potential shared code of ethics for all health care leaders not just physicians but health care HMO executives and health care system CEOs and other people who are not the beneficiaries of Hippocratic Oath or some version of that on the physician side.

We are also going to look at an issue very similar to what you're going to and I hope it will not be

duplicative at least in the sense it won't help you. We are going to try and take our own look at the regulatory framework for managed care, try to decide -- and I should say that we are by and large a group that believes that managed care is a better system for organizing and delivering at lower costs with the same or better quality; but it clearly is a work in progress. We haven't invented the perfect forms of compensation systems; we haven't invented the perfect products. We think we're on the right track.

We're going to try and look at the essential public protections for consumers that the marketplace will not meet. I think by and large we're going to support innovation, creativity, competition in the marketplace. We think that's good, that's healthy. In the same way we probably wouldn't want a mandate everybody having consumer feedback model because it takes away a certain part of the creativity.

There are some issues, there were many issues in which the competition for quality will produce better results clinical and otherwise. But having said there are still a set of functions that the marketplace cannot and will not fix and it definitely will have to have some public agency oversight and some public regulatory framework.

We're going to sort through one of the essential regulatory functions. What are the core competency you have in the regulatory body that performs

those functions, and probably for us third where might that body best be housed. I have a sense you may take the third part first, for reasons of -- unrelated to the work plan perhaps. I'm not sure we're going to produce a recommendation on which department is going to be the best managed care regulator. We're not sure whether it's appropriate for us. We may not help you in that regard, although my sense of the board is we probably would recommend that it be an appointed head and not an elected official so there's better accountability.

Then we're going to try and find a list of issues and activities that benefit consumers and purchasers because they provide better information, patient satisfaction survey is good, outcomes data, readable English language version of the Department of Corporations patient complaint list; the kinds of information patients need on drug formularies that HMOs have or physician compensation arrangements. Many of these things that are not necessary in terms of protection but which are helpful and necessary for consumers and others to have to understand the relative merits of different HMOs and different medical groups.

And finally because there's so much legislation and other activities in the name of consumer protection we will probably create a list of things that are labeled as consumer protection which we think really are really more special interests. And you may or may not agree with any or all of those.

That process as we unfold it over the next several months we will draft materials, if my board is comfortable doing that, to you. We may only be able to share them directly with the chair and staff directory and you may decide what's shareable, but I encourage you as you go through your own work to separate out those necessary essential protections from issues that ought to be incentivized for which there ought to be standards but you don't need to write a piece of legislation or regulation that tells people exactly how to do it and make judgment may be in the more of provider or other special interests and not so much consumer interests.

Thank you very much.

MR. ENTHOVEN: Thank you. Thank you very much, Mr. Carter. Thank you.

Next we'll hear from Mr. William S. Choate from Fresno Madera area agency on aging and California Senior Legislation.

Mr. Choate.

MR. CHOATE: Thank you.

After listening to the presentations thus far I feel a little bit like Charlie Brown looking thorough the clouds; I don't see Beethoven, I see a bunny rabbit.

I would like to make three statements on the effect of managed care upon my relationship with my physician, personal statements but not too personal.

When managed care came to Oakhurst,

California, my physician resigned from his group and notified his patients that because he could not professionally submit his medical decisions to non-medical approval, he could not serve their needs in their best medical interests. I changed back to a doctor in Fresno. Although he maintains at the present an independent practice, I think that there are pressures upon him to submit to managed care.

MR. ENTHOVEN: You said non-medical do you know that or is it --

MR. CHOATE: This was in a letter he wrote to me, to all his patients.

MR. ENTHOVEN: Because it might have been his peers in the group who were --

MR. CHOATE: There have been so many changes in doctors in Oakhurst that I can't recite them all. Friends of mine have said that with one very qualified young man, who has since left, he left because he was required to limit his time to the patients to eight minutes. That puts the hackles up on the back of the neck, but it's not a professional statement it's simply hearsay.

I do recall in my doctor's office here in Fresno a 15 minute delay of his dealing with me because he received a phone call in which he had to support his decision for expert medical attention for another patient with the insurance company.

One other thing as a lay person, but in

preparation for the senior legislative session last year, and with the aid of a six month free subscription to -- what's the business journal --

UNIDENTIFIED AUDIENCE MEMBER: The Wall Street Journal.

MR. CHOATE: Wall Street Journal, thank you. We get forgetful because I'm also a senior.

I noticed five or six purchases and mergers of HMO organizations by what seems to me in that paper in the reports to be non-medical corporations. Is this simply a profit motive? If it is perhaps it needs to be watched. And then a question occurred to me this afternoon in listening to the presentations and so on, is HMO in the United States socialized medicine for profit?

MR. ENTHOVEN: You're asking me?

MR. CHOATE: I don't know.

Thank you very much.

MR. ENTHOVEN: Any questions? We'll reflect, no questions, thank you.

Ezunial Burts.

Thank you for coming all the way up here.

MR. BURTS: Thank you, Mr. Chairman and members of the Task Force. I appreciate the opportunity to appear before you today.

As you mention my name is Ezunial Burts, I'm president and chief operating officer of the Los Angeles area Chamber of Commerce, an organization which represents the diverse business interests of the counties of Los

Angeles, Orange, Riverside, San Bernardino and Ventura counties.

The Chamber has designated health care, specifically the provision of health care insurance for the uninsured, as one of our six priorities for 1997. We recognize the importance of maintaining the health care safety net and all of its segments, one being managed care. It is of critical importance that a venue for discussion of managed care be held since it is responsible for such a significant portion of health care services. The Chamber commends the work of the Managed Health Care Improvement Task Force in bringing together sections of the community in order to build a consensus on such a critical issue.

We are fortunate in this state and in this country to have one of the finest health care systems in the world. We've devoted a significant portion of our gross national product to this end. The business community recognizes that a healthy population is in the best interests of business as well as society. A healthy society is likely to be a more prosperous society. For this reason, business contributes the predominant share of the cost of health care. It was not long ago however, that our investment in health care was growing annually by double digits. Fortunately these annual increases abated due in large part to the advent, growth and emphasis of managed care.

We view managed care as a conglomeration of

efforts to maintain and improve the quality and delivery of health care by the most efficient and effective means possible. Examples include not only health maintenance organizations but preferred provider organizations, and point of service plans. These efforts are important in providing health care to society at a cost that is acceptable and that keeps our economy and its businesses competitive in an increasingly globalized marketplace.

The Chamber is an advocate for managed care for the purpose of maintaining a strong health care safety net. The Chamber's health care policy calls for universal coverage by maintaining employer-provided private sector insurance as the primary source of coverage and for an emphasis on market forces and competition rather than on regulation as the basis for cost control.

The policy also calls for support of managed care that would not compromise managed care's ability to develop cost effective provider networks which would result in decrease competition and higher prices for consumers. The Chamber strongly supports managed care based on the cost effectiveness and integration of quality insurance.

Studies have been conducted that validated our basis of support for managed care. According to a recent study released on May 6th of this year of the Barents Group, a Washington, D.C. based financial and economics consulting firm, preferred provider plans and point of service plans save 14 percent in health care

costs in comparison to the previous operation methods of fee for service plans that do not conduct utilization review. In addition, independent practice association HMOs save 23 percent and group and staff model HMOs provide a 30 percent saving over fee for service.

Proposed state and federal mandates, however, would significantly reduce these savings to employers and consumers. These changes to managed care would have an adverse impact on health care consumers because employers facing higher health care costs could be faced with having employees pay a higher share of premiums, reducing wages, or dropping health coverage entirely. Furthermore, as the Barents Group indicates, enactment of the proposed mandates could reduce the spillover effect of health plan market presence, in which efficiencies achieved through health plan operations ultimately increase competition and therefore help keep cost at a minimum throughout the health care system.

The Chamber recognizes that reforms that could hold managed care plans liable for action of their health care providers would increase health plans cost. The Barents Group indicates that these costs would increase by 4 to 5 percent. In fact, the study cites recent congressional budget office data which suggests that these increases could be as such as 12 percent. The study attributes these costs to several factors; the increased practice of defensive medicine in which physicians order more test and procedures than are

medically necessary -- that would occur if such a proposal were implemented; the cost of additional liability insurance and administrative cost associated with the mandate.

Given the Chamber's focus on the uninsured, it is of great concern that the strides made in allocating insurance for this segment could be placed in jeopardy if managed care is subjected to mandates. With the absence of managed care and competition brought about by mandatory coverage and restrictions, premiums would go up. National studies have found that by raising premium costs, such mandates ultimately increase the number of uninsured. National studies have found that with each one percent increase in premium costs, small businesses sponsorship of health insurance drops by 2.6 percent, and 200,000 Americans could lose coverage. The high impact health care mandates will ultimately affect access to care for the entire population. For Los Angeles and for our region this is even more pronounced.

Currently, Los Angeles has the largest proportion of uninsured than any other area accounting for more than 2.5 million residents. This significant uninsured population has created a volatile scenario where any decrease in health care service can cause or create a trauma care overload and a shutdown in the health care delivery for all. According to the UCLA Center for Health Policy Research, 85 percent of the uninsured are working individuals and their dependents. This is based primarily

on the fact that a large amount of residents are employed by small companies primarily in the service sector. The number of working uninsured is expanding because the type of employment that is growing is primarily self-employed, part-time or temporary, all of which are least likely to offer health insurance.

Uninsured residents often forego routine preventive health care treatment because of costs. They are likely to avoid seeking care until the situation becomes critical. When this situation occurs, they go to the emergency room where legally they must be treated regardless of their ability to pay. While this may be the only economical reasonable alternative for the individual, it is unreasonable in terms of good health care practice and in terms of money spent, since treatment in an emergency setting is the most expensive means of providing health care that usually aiding an illness that has reached a critical stage.

Because the uninsured enter through the emergency room, many hospitals face serious financial problems. Their ability to make up the losses is by cost shifting which is adding the percentage of uncompensated care onto the bills of paying patients thus increasing premiums for business and individuals. Some hospitals have closed their emergency rooms entirely, while others have been downgraded from trauma status to stand-by. When this situation occurs, service is curtailed to all residents and not just the uninsured.

The Chamber has assembled a task force that is focusing on developing policy that will address the working uninsured. By advocating for legislation and less regulation that will promote tailored managed health care plans, strides can be made to provide health insurance for this population, we believe.

Despite the continuing debate on an resistance to managed care efforts, we believe managed care is here to stay. Our purpose here today was to voice our support for managed care and propose a set of recommendations on how to improve our current efforts in managed health care.

Let me summarize some of these for you. Increased educational efforts on the advantages of managed care to medical profession students, providers, employers, employees and other health care stakeholders; encourage and promote the partnering/working together of health care providers and managed care professionals; increase emphasis on preventive care and wellness approaches that encourage patient responsibility and accountability for their own health; emphasize the control of health care cost, not in terms of minimization but effectiveness, efficiency, and prudence; promote the use of community health centers and home health care as alternatives to the use of large hospital based health care delivery. Finally, and most importantly, allow market competition rather than legislation to regulate managed care -- do not over regulate this effort.

In conclusion, I want to commend the Managed Health Care Improvement Task Force for providing a platform to address this issue. We at the Los Angeles area Chamber of Commerce pledge our continued support, input and assistance in addressing managed care because we truly do believe that health care safety net for tomorrow depends upon our actions of today.

Again, thank you for the opportunity, I have copies for members of the Task Force.

MR. ENTHOVEN: Thank you very much for coming.

MR. WILLIAMS: Thank you. I would like to commended the Chamber for taking a very strong interest in the availability particularly for the working uninsured because it is a very serious problem in the L.A. area, actually nationally but accentuated in the L.A. area, and I think it's important to note the business community is very concerned about this important issue.

MR. BURTS: We're watching this one carefully.

DR. SPURLOCK: You mentioned and actually I was quite impressed with the fact that you put health care of the uninsured as one of your key 1997 priorities and you talk about incentives for managed care and efforts to improve that. What other efforts might you undertake or use as the chambers "pulpit" in policy direction to deal with the huge industry problem especially in L.A. County. It's growing faster than anywhere else in the state and

the magnitude of the need of that is very critical.

MR. BURTS: We began by looking at the entire health delivery system and began to look specifically at this huge population of uninsured and that is one of the primary activities of this task force that we've created. They're in the process of looking at the number of recommendations, and I believe within the next few weeks we'll come up with a series of specific recommendations on how we might address this issue. We'll adopt that as a policy or some variation and we will begin to speak out on this issue because we think this is critical. You'll hear more from the Chamber on this issue with some specific recommendations.

MR. KERR: Other questions, Mr. Rodgers.

MR. RODGERS: I did hear you say that you do support mandates on employers in terms of health care coverage, is that what you said?

MR. BURTS: No. Not should be underlined.

DR. ALPERT: In follow-up in clarification you opened I think with saying that you argued for employer provided insurance?

MR. BURTS: That's correct. That's correct.

MS. DECKER: Just mandated.

DR. ALPERT: What I'm getting at is suggesting avoiding mandates so as not to increase the number of uninsured, but I'm more interested and what I hope I'll hear in the future is to take what we have now and decrease that.

MR. BURTS: It is interesting because I believe there should be health care provided. But when you see a large segment of the population not served, I believe that is also a responsibility of a responsible business community.

DR. RODRIGUES-TRIAS: Thank you for the testimony because I think it's really important to look at it as this is all our problem and not just one city.

MR. BURTS: That's exactly how we view it.

DR. RODRIGUES-TRIAS: What I quite didn't understand, and I don't know if I misheard, you said something about the quality standards imposed on the existing managed care may have an affect of decreasing the available resources which I'm not sure whether it's quality standards or profits or where.

MR. BURTS: The concern is really about how you share the cost of providing that service and as that cost increase what will employers do, how will they share that cost, will they pass it onto employees, will they reduce wages and salaries and will employees choose to create an even larger pool of uninsured. That's the concern.

DR. KARPF: But quality of cost may have some relationship but it isn't a definite correlation in some circumstances --

MR. BURTS: That's correct.

DR. KARPF: -- there have been health care systems that have shown by carefully looking at process

improvement one can improve quality and decrease cost and that is a fundamental root as a competitive industry, right?

MR. BURTS: I believe so. Especially in this state I believe it is more critical because the competition is not just domestic it's global.

MR. KERR: Bruce.

DR. SPURLOCK: Yes, I wanted to make two comments. While the uninsured issue is not on our table, on our plate for our Task Force, I think several of the members would be very interested to see your policy report when it comes out.

MR. BURTS: We'll make sure you do.

DR. SPURLOCK: Second part this cost tradeoff with quality improvement, you know there's a lot of data to increase preventive care actually increases costs and there's nowhere where that's more truly than in mammogram controversy. Mammogram at age 50 to age 65 to 70 cost is about $30,000 per life so it's a net add into the system. If we increase preventive care, there's actually a potential we could increase costs in some environments. How would you deal with those kind of issues?

MR. BURTS: I'm not a medical expert and I don't propose to have an answer to some of those specific issues, and that's why I do believe that the importance of this task force needs to be underscored. I believe the work that is taking place here and the report that you'll

produce early next year has to address some of these critical issues, and we're here to point out some of the problems within the purview of the task force but that there are other issues sitting on the sidelines that are just as important. And I believe you have to provide not only a forum for commenting, but I believe it is incumbent upon you to raise some of those issues. I don't know all the answers to some of those medical issues.

MR. KERR: One of the reasons for health care is to save lives, and I remember being struck by the fact if you catch a cancer at stage one verses say stage three or four, some cancers like colon cancer you have a 700 percent better chance of surviving; that's important from the human standpoint. I also remember seeing some United Health Care Plan data several years ago that indicated that catching a breast cancer saved them, the HMO, about $132,000 more than if they didn't catch it until stage three so it gets --

DR. SPURLOCK: That's a difference in screening mammograms which adds to the system and screening colon cancer screening adds to the cost of the system it's different than catching a cancer earlier, that's what we're looking at --

MR. KERR: Except one of the best ways to catch a cancer earlier is obviously by doing screening.

DR. SPURLOCK: No, I understand that --

MR. KERR: Maybe I'm diverting the whole topic.

DR. ALPERT: Just a final -- and I'll be very interested to see what your suggestions are for the future and I hope that you use the laboratory that's already been started that is the State of Hawaii which has created the employer mandate that you were saying should be avoided and I think you'll find as you analyze that that will support your analysis because it's probably maybe the only state whose economy has been devastated in the last few years as the rest of the states in the United States have come up, and there's other factors playing into that, but you might help by trying to pick out the employer mandate for ensuring everyone as to what part that played in the devastation of the economy of Hawaii which has taken place.

MR. BURTS: Interesting because there are similarities.

MR. KERR: Any other comments or questions at this point?

Alain had to leave and he has six more people in 30 minutes and that literally comes to five minutes a piece and he gave me the job to enforce it. So I would like to call Dr. Klaus Hoffmann.

DR. HOFFMANN: That's close.

Good afternoon, I promise to stick with five minutes. My name is Klaus Hoffmann --

THE REPORTER: Okay, excuse me. I know you have five minutes but --

DR. HOFFMANN: Will you give me six?

My name is Klaus Hoffmann, I'm a medical oncologist for 20 years in town and I appreciate the heartiness of the remaining members of the committee, of this volunteer committee.

I am here to speak for myself and what is happening in my practice. I understood that that was interesting to you.

While managed care is reducing health insurance premiums for the employers, it is doing so by taking away from the essence of medicine. It adversely affects the patient-physician relationship in several direct and indirect ways and it decreases access -- you'd like to hear that, right -- to care even when such care is clearly needed and indicated. Delays in denial of care are being used as a routine tool to avoid spending insurance premium money on patients. Only after tedious and repeated explanations and protests by physicians and patients are some of the denials reversed. In my specialty of medical oncology such delays are not always free of adverse effects and on the outcome.

In much more insidious form of rationing -- because it is less obvious to the patient -- takes place under so called capitation arrangements. In such arrangements the "insurer" shifts the risk of costly illnesses occurring and needing treatment to the physician. So called stop loss provisions are meant to mitigate large losses but do not affect the day to day detriment generated. The physician is put into a new kind

of conflict of interests. Capitation payments typically cover less than the previously provided standard of care. Treatment decisions affect the expense to the capitated physician and, for non-capitated portions of care, also to the insurance plan. Particularly in oncology, the decision making difficulties are compounded because the outcome in many cases is known and bad, that means patient dies. The malignancy is not curbable but it may be treatable. The patient and his family suffer from these consequences. The system is clearly designed well -- it is naive or dishonest to expect that physician's decisions are not consciously or subconsciously influenced by such considerations of cost to them. I'll read you examples.

The system is clearly designed for this purpose, with the belief, that to some extent, this conflict of interests physicians find themselves in, will be resolved in ways that reduce outlays. What makes such influences more ethically troublesome than others is that patient in general are still ignorant about these considerations tainting their caregiver's recommendations; patients are passive in the process of denying or rationing care. In contrast, more pay for more services are generally business principal and easy to understand and even unnecessary services, and procedures and treatments have to be explained and agreed to.

If this system of managing health care is allowed to persist, it will be more difficult for future generations of physicians to adhere to the Hippocratic

Oath. They will also live with a new form of legal liability. I can certainly think of better ways of deciding what is necessary, desirable and affordable, than to have physicians and collectors of health care premiums tacitly or overtly do the rationing for disenfranchised patients. After all, while the average consumer does not write the health care premium check, it certainly comes out of his pocket in a day's work.

The few examples I would like to quote all happened in this brave new world of managed care in my practice in the last month, except the first. The patient's named are coded. Eighteen months ago a large employer changed its members to an insurance plan with which my office was not contracted. Fourteen of my patients were told they had three months to find a new oncologist, even though some had ongoing treatment for their malignancies and had been under my care for over a decade. It's the same company whose representative told us some 10 years ago at the Ramada Inn meeting that she would force a woman who has had three children with one gynecologist at one hospital to have it will with a new gynecologist at a new hospital that had contracted with them again. It took a barrage of phone calls and letters from upset patients to the company to allow us to sign a contract and to continue caring for these patients. As to the economic rationale of such forcing a group of patients with serious illnesses to find new physicians, I'm at a loss. Even disregarding the risk of losing important

information in the transfer harming the patient in dropping the ball, it's very expensive to establish new patient-physician relationship, so I'm not sure why they did that.

Next is more recent things. A 55 year old very functional woman with kidney cancer involving lung and bones was progressing after hormone treatments and causing symptoms. It took an entire month of practically daily phone calls from the oncology nurse, the insurance clerks, the patient and myself to her HMO, it's agents and contracted pharmacy in order to obtain the interleukin 2 an expensive biological response modifier on the market exactly this condition. After the initial flat denial, which we usually receive from people without any understanding of the medical issue, the tactic switched to putting up so many hoops and changing them constantly as to result in a catch 22 -- and no treatment for the patient for one month, to which her pain worsened the tumor regrew or grew further. And I'm convinced, that mentioning "I" word and the "S" word, I'm sure you know what that stands for, were instrumental in getting her access to her care. And I've seen her today, the tumor is shrinking, and it didn't have to be but she needed her day in court. She needed a chance to get treatment and it took all that.

On 6/4 I received a phone call from a retired physician doing medical review work for an insurance company on my patient who is 53 years old and

has had multiple myeloma for four years, that's a form of bone destroying bone marrow cancer. He presented with extensive crippling bone destruction making it impossible for him to sit in a chair for the initial consultation. On chemotherapy he is now well, asymptomatic and working full time and playing handball better than I can. He has also received, in the past year, monthly infusions off Aredia, that's a medication which was proven about one year ago to significantly reduce fractures or broken bones and symptoms from bone destruction if used in this fashion in patients with myeloma. The doctor flatly stated that he was lacking information on the issue, that he did not know the patient's calcium level, and not withstanding my explanations, I gave him Aredia only necessary for control of high calcium. His job was to deny the further use of it. We would have to go to appeals anyway.

MR. KERR: We've reached five minutes, can you wrap up and give us your final ten seconds.

DR. HOFFMANN: Yes.

Well, this patient has political connections, he will fight.

The next is on paper here somebody had great difficulties last week getting her medication because it took about three and a half weeks to get medication from out of town pharmacy.

Last month, after nine years in remission, a lymphoma patient, 63 years old, suddenly had converted to a leukemia which needed extensive hospital treatment.

MR. KERR: Maybe you can submit the cases to us, you can wrap up comment --

DR. HOFFMANN: Wrap up comment goes into this one. The service provider in one month with this patient now exceeds the entire capitation payment for all the patients in my practice. If that's not a conflict of interests I don't know what is. I'd be happy to expand on that further, there are better ways of rationing care and that's what we have to do is we have to ration care. I think patient autonomy would have to be in there and Mr. Reed mentioned basic principal if this connection between cause and effect between who pays for it who makes the decision.

DR. ROMERO: Doctor, I would very much to have a copy of your --

DR. HOFFMANN: Yes.

THE REPORTER: I would like one too, please.

MR. RODGERS: My only question is you've generalized the whole HMO business as the problem. Are there any plans that you work with that you feel are model plans? Yes or no.

DR. HOFFMANN: No. Besides I think your first statement is not true. I have not generalized them I've told you what's happening and I mentioned five examples. It happened in one month.

MR. RODGERS: You don't know of any plan that you work with that you would say this plan is okay.

DR. HOFFMANN: The principal is the same

that somebody has to tell the patient not to get the care and the people who will make that decision or make us do that have switched to making us do it for financial reasons.

MR. KERR: Thank you very much.

Don Fielding.

Again, I'm sorry, we're trying to let everybody have a chance to talk before we have nobody up here.

MR. FIELDING: Thank you. I am with AARP vote but I'm going to take, as Mr. Reed did, I'm going to take off my AARP vote hat and I'm going to talk about my own personal experiences and observations about managed care.

Part of the issues that I speak about will be the result of some of the policy orientation that I've received through AARP. By the way, I don't know if you all have heard what the United States Senate Finance Committee did yesterday regarding Medicare, but they made radical changes in the way Medicare is going to be operating.

MR. KERR: Could you speak into the mike.

MR. FIELDING: The finance committee of the Senate made radical changes in the way Medicare will be operating in the future should the bill receive or the suggestions receive a vote on the floor of the Senate and should the process continue through to let the President sign. This will have great impact on seniors who choose

to join managed care plans.

I am going to give a scattered series of comments about managed care. I'm amazed at your ability to look at both the global and narrow issues and the perspective of consumers and managed care plan administrators and physicians and it's herculean task.

One issue we've been concerned with recently is a termination of physicians for managed care plans. Last year it's my understanding that the state legislature passed a gag rule prohibition and it disallowed managed care plans from preventing doctors from discussing possible treatment plans. I also understand that as the situation exists now, managed care plans have been able to circumvent the gag rule legislation by terminating physicians for managed care without cause with a 30 day notice, apparently often part of the contractual arrangement. I think this is rather devious attempt to circumvent the spirit of legislation that was passed in the area of dealing with doctors who feel the need for full disclosure in discussing all medical options with patients.

I think that my main concern about managed care as it has unfolded in my experience, it's consumers are overwhelmed by the process by knowing how to choose a managed care plan and how to wade through the bureaucracy of a managed care plan.

One of the individuals here today, I believe he was health care administrator, talked about wanting to

increase the amount of education that plans provide to recipient or to consumers. I've heard that and I hope that the man was genuine and serious, I have to reason to think he's not, but consumers do not understand the managed care process with capitation and with a form that has allowed a doctor to use certain treatments for certain conditions and certain drugs for certain conditions. They don't understand an awful lot of how decisions are made about their care, and I don't think managed care plans want full disclosure regarding all issues related to the decision making process.

I thought it was interesting that the gentleman from the Chamber of Commerce from Los Angeles talked about not over managing managed care programs. That's not happening. I'm amazed that he would see that as a potential problem. I also notice that one of the comments he made in his recommendations was that they increase educational efforts on the advantages of managed care to medical professional students, providers, employers, employees and other health care stakeholders. A front page article in the Los Angeles Times about two days ago included statement by the chancellor of the University of California medical school on the results of a commission which recommended that the medical curriculum be expanded to include issues concerning business operations and the ability to function within clinic settings.

Now if we were going to include in medical

curriculum information about how a doctor can better practice business practices and not include some of these other issues that I think make managed care a less than desirable way to provide all medical care -- in other words discuss the pros and cons of seeing business aspects and clinic settings for doctors. I almost see this as -- I don't fully understand why we would want to expand the curriculum in medical schools in this area but it seems to be possibly related to the Chamber of Commerce interest in making sure the business aspects of managed care are understood.

Is that my five minutes?

MR. KERR: Just about.

MR. FIELDING: Okay, thank you very much.

MR. KERR: Questions for Mr. Fielding?

DR. ROMERO: Just one quick follow-up. On the first issue you mentioned which is that your research some plans are circumventing the gag rule by terminating without cause. There's a school of thought and some bills in the legislature that argue in essence there should be more checks more constraints on plans ability to terminate contracts. In essence in employee terms it would be like going from an at will employment to one where cause is required. That in a normal employment relationship that starts to look like -- what often happens, studies have shown, is what happened is the employer start practicing not defensive medicine but defensive employment. They start retaining low productive employees because they

can't -- they fire them. Should we be concerned about that with respect to contractors to providers?

MR. FIELDING: No. I think the alternative is terminating someone with no cause, with no explanation, that certainly can't be defended. Particularly if the suspected motivation is that the physician declined to participate and not discussing certain treatments. What you talk about being forced to keep poor performing employees could apply to long term government employee, could apply to school systems --

DR. ROMERO: It does apply to school systems.

MR. FIELDING: But it will ultimately amount employees having certain rights to just determinations. But I understand your point.

MR. KERR: Any other questions for Mr. Fielding?

DR. ALPERT: My response to Phil, I think this probably again a lack of understanding of the daily workings of some of these particular quixotic relationships that occur in exactly what this gentleman is talking about what the determination of plans, and like everyone else I might as well call on an anecdote. I was entered into a plan --

MR. KERR: You have five minute.

DR. ALPERT: I was enrolled in a plan, terminated from the plan, and re-enrolled in the plan within about three week period without ever having any

correspondence from them to me or me to them or responding to anything. I simply received three successive missiles from the plan telling me that these three things were happening, that I was being enrolled, and I signed the contract and then I was disenrolled and then I was re-enrolled without any mention of anything.

DR. ROMERO: To this day?

DR. ALPERT: Yes, I have an idea and that will go beyond my five minutes. But it exemplified --

UNIDENTIFIED COUNCIL MEMBER: This is very understandable these kinds of things happen and there's not brilliant stuff going on.

MR. KERR: Other questions.

MS. SKUBIK: I'd point out that the plans they were dealing with the issue a couple years ago in the legislature if you give cause for termination you can have lawsuits it makes it --

DR. ALPERT: That's what happened obviously --

UNIDENTIFIED AUDIENCE MEMBER: It's arbitration process AB 34.

MR. KERR: I would like to give the audience a chance and we're talking among ourselves.

Next is Dr. Alex Sheriff. Three minutes, I'm sorry to do this to you.

DR. SHERIFF: My name is Alex Sheriff, and I'll try to keep it closer to two minutes than five minutes. I'm a family physician in practice in Fowler,

California, which is a community of about 3600 between here and Selma primarily an agricultural based community. About half of my practice is probably so-called managed care patients, about a third or so through Medi-Cal, and the rest of the variety of other plans are cash payment.

I've also -- I wanted to speak today particularly to Medi-Cal managed care. I realized that's not the major charge you have but it's an important issue in managed care, very important in this county, it's 120 or 150 thousand individuals and I've been involved in some of these issues for I cannot remember how many years as our local community struggled to form a local initiative but was not successful. So we're one of the lucky counties that has two mainstream local initiatives.

The implementation -- both the mainstreams came online in April and it's been a less than smooth process. The stated goals of managed Medi-Cal were access, choice, quality, savings, my memory served me that was not the plan. The plan was not to save money, if there were savings the money was supposed to go into improved care for access for services. The implementation has been very difficult. I'll share a couple of episodes from my office in just the past couple of weeks, and a lot of the dust has settled since the beginning of the two plans in April, but there's still many, many problems, and I think I certainly have heard from other practices of difficulties.

The rules are not obvious to people and the

rules are not obvious to providers; the rules are not obvious to the patients. I had a patient Monday who was bringing her child in for well child care, the child was three months behind on immunization and I asked -- only because it was on my mind because I had gotten a flyer about this meeting -- gee, how was it signing in for managed Medi-Cal, how did it go? And the patient's response was Oh, no problem. I said, well, okay, tell me about it. Well, no problem. She'd seen a sign in my office that said we were Foundation Provider. Now she didn't know that meant Foundation Commercial not Foundation Medi-Cal. So when she got the packet she said, oh, my doctors are Foundation, I'll sign up for Foundation. Well, we are not Foundation Medi-Cal providers, so she was now Foundation Medi-Cal. Now by the time she figured out this was not going to work now she has to change plans. It took her two months to finally work through the system and get it straightened out.

Had another patient the week before who came in absolutely in tears because she had been told by Blue Cross that Dr. Rubenstein, my partner, was not a Blue Cross provider. Well, he choose to be a provider for one not both to have not quite so many hassles to deal with as it started up. My partner is a Blue Cross provider, it took a number of calls to get this straightened out and clarify in deed my partner is a Blue Cross provider.

I want to commended the plans for the efforts they've made to improve things, but we had this

problem a month before. So it wasn't -- it's confusing for patients, it's caused problems for access. Patients have had difficulty getting to their traditional providers, to their primary care providers. It's very frustrating for providers and I'm concerned what's happening to access. I know primary care physicians who have heard about the problems and decided they will not participate and have informed the Medi-Cal patients of that. I'm concerned about what's going to happen for specialty access because specialists are certainly concerned and I don't think my office yet has a specialty provider list for these plans. They have to call and find out if the provider is willing to participate.

I have grave concerns about what's happening with quality because certainly we're spending more time with patients who are involved in these programs but it isn't time on patient education, it's not time with the real stuff going on in their lives, it's holding hands sorting through administrative issues, time on phone verifying eligibility, whether we're really the primary care provider and if we're not, we should be, is there traditional provider working through their system.

MR. KERR: That was five so can we just get your --

DR. SHERIFF: Sure. I don't have an answer but I think it's clear that we need more oversight, we need to know what are in these contracts, whether the standards, the plans are supposed to be adhering to and

what do we have to do to be sure that they actually perform accordingly. I think certainly in Fresno County this has been implemented too quickly without considering the implications and without having the system in place to really make it work and succeed.

MR. KERR: Sorry. Questions for Dr. Sheriff.

DR. ROMERO: I have one question, Doctor. Many of the problems you've been describing are in essence associated with the enrollees entrance into the new plan. Do you have any comments on once they have been in the plan for a few months whether there's any real difference in their medical experience as opposed to fee for service Medi-Cal?

DR. SHERIFF: We haven't been in it for a few months yet so it's too soon to say. I have real concerns about how a chronically under funded system is going to make due with what's clearly going to be less in the future and it's less now. It's my understanding the state spends .95 on the dollar from what they were spending before for Medi-Cal into the managed care system. And I certainly have concerns about the long term implications and whether plans are going to be able to deliver on the promises.

MR. KERR: Any other questions for Dr. Sheriff? Thank you.

Next speaker will be John Donaldson from the local health coalition.

MR. DONALDSON: Good afternoon, I'm John Donaldson from the local health care coalition. I have a few things which I'll try to make quite quick.

My first Time magazine had what I thought was an excellent article on the backlash against HMOs about two months ago. I'll just quote one thing from Dr. David Lawerence, chairman and CEO of the state wide Kaiser Permanente. "In the fee for service days, it was very perverse system that rewarded doctors for doing way too much medicine. Now we have a system creating incentives to do too little."

It's pretty obvious there are some emminent economist perhaps even on this panel and chamber of commerce that think regulation is unneeded for HMOs. I just don't believe that anything in which case -- that's made like this where the incentives are to do too little. And I believe that this CEO stated it very cleanly and nicely. Where the incentives are to do less, I believe regulation is going to be a necessity. You've all heard the horror stories, the unconscionable things that have happened in some of the HMO settings just cannot be allowed in the civilized society and we're going to need to regulate -- through the state, I don't know who else -- more not less. I think regulation at this point -- Ezunial Burts is not worried about but regulation is at a very -- well almost subminimal level and it's going to have to be increased considerably before the system is workable.

I'm concerned partly because I believe we're probably going to have to continue with HMOs at least until we get a universal health care system of some kind even that may be through an HMO when it happens. At present the way the backlash is developing I believe that the HMOs are going to be -- they are going to find they cannot stay in business unless these things are corrected. Perhaps the marketplace will make them do it but the evidence so far is that the marketplace is not going to be able to do it, we're going to have to correct it in order to keep cheaper medicine for the state, for the employers, for the individuals.

There was a suggestion that we need to increase the information. I have to agree with the person who spoke just a few minutes ago to that. Most consumers I believe are greatly overloaded in information right now. Again, I'm retired from State of California. Every year we used to get this great packet many, many choices as to -- of course you had to first go through and find which applied to this area and then knock out those and still there were many choices.

I'm a retired professor of physics, I feel I can read pretty well but that was very difficult job to try to figure which one of these is the best plan for me. People who are particularly Medi-Cal, people who are at a much lower level of education are going to find that job completely impossible in my opinion.

Finally, there was a quote in the morning

paper from a conference yesterday morning at a chamber of commerce conference which seemed to me again to strike the particular note that's the key one in this. The doctor in this case said the patient-physician relationship is being replaced by the patient insurance company relationship. I don't think that's workable.

MR. KERR: Thank you very much.

Do we have questions?

Thank you very much.

Final speaker is Dr. Linda Hewett, UCSF president of the Alzheimer's Disease Center.

DR. HEWETT: Good afternoon. Thank you.

I am co-director of the UCSF Fresno Alzheimer's Disease Center, I'm not a physician I'm a neuropsychologist.

Our center is it one of the nine multi-disciplinary diagnostic and treatment centers throughout the State of California. We are state funded, part of a connected system.

As far back as 1993 our centers formed a committee to monitor and identify problem of access to care that many of our clients were experiencing once they had signed up with managed care programs. Health maintenance organizations recruit elders aggressively, and while there are many advantages for these elders, we have continued to be disturbed by the signing of cognitively compromised elders who have little sense of the consequences of their decisions.

Moreover, when members then seek diagnostic work up for dementing disorders they are regularly confronted with a lack of response from their providers, and/or refusal of the program to pay for diagnostic tests such as imaging studies and other work up. Of most recent concern has been the refusal to facilitate referrals by the program's primary care physicians of their patients to dementia specialists outside their program, which would certainly seem to us to constitute a restriction of care. The availability of dementia specialists in the community at large is small. And yet the State of California, in association with the finest medical schools anywhere, has put a system of experts in place, accessible to every community for just such consultation.

Of course, when families come to our centers anyway, they choose to pay out of pocket to avail themselves of our expertise. In turn this means that the State of California is underwriting managed care companies, since we discount our services in order to avoid further financial insult to the patient and his or her family and facilitate the in-depth evaluation the family is looking for.

Increasingly we respond to family caregivers who are unable to get any kind of help for their loved one, not even a community referral to a support group. It is almost impossible to detect dementia in the early stages in a 15 minute office visit, during which the physician directs the conversations, and the patient is

able to maintain a facade of intact functioning.

Nationally, the community standard of care and management for dementia is seen as a multifaceted process, and many community resources have been put in place to support such families. Cost-effective care that promotes quality of life is available to increasing number of persons suffering from a progressively dementing disorder. However, such access to such care and support is irreparably delayed if no diagnosis is forthcoming. It is certainly not cost effective to repair damage that could have been prevented by access to timely and sensitive care.

At a bare minimum, managed care must address the issue of diagnosis for persons presenting with complaints of cognitive dysfunction. Of critical importance is provision of in-depth investigation of those who present for diagnosis, especially early-onset medically complex cases, either by referral to experts within the managed care system or by referral to those centers of excellence outside the programs. Resource referral to the educational and psychological support services of families needed to maintain their loved ones at home, or in their community for the longest possible time is a basic requirement.

The State of California has invested tax-payer money to develop wide reaching, state-of-the-art services for its citizens. Elders above all, have earned the right to adequate care and support but are often kept

from receiving it by managed care policies. Partnering would seem to present a viable alternative whereby diagnostic services for difficult or unusual cases would be available through the centers. In addition, our research programs, education and training programs, and our extensive community ties would enrich and benefit the clients we all serve.

In conclusion, the perceived managed care problems are: lack of access to a diagnosis; a refusal to refer for specialist care for complex cases; a lack of education for family caregivers; lack of support services for patients and family caregivers; an unwillingness in some case to prescribe and monitor either of the only two pharmacological agents available for Alzheimer's disease treatment; and a persistent refusal to negotiable contracts for provision of already developed services providing state-of-the art care.

And I heartily endorse Dr. Hoffmann's remarks on dementia is no popular than cancer, thank you.

MR. KERR: Thank you, Dr. Hewett.

Do we have questions? Yes, Barbara.

MS. DECKER: I wanted to ask I gather you're representing the Fresno location for UCSF, do you think these problems are essentially similar in all the other locations throughout the state? Do you have the network?

DR. HEWETT: I know they are. I chaired a committee that came together which we initially called an HMO committee because it was very much HMO problems. I

think the problem is wider than HMOs that dementia is not a popular disease and people don't like to work it up. But increasingly across the state the managed care programs are very, very aggressive and increasingly we've reached saturation in San Diego, in Sacramento. There are a number of programs where people come constantly to my center and to all of the other eight centers across the state for help which they cannot get through their own managed care programs and they pay substantial amounts of money out of pocket to help their family to find information and to learn where they must go to help their people.

MS. DECKER: Do you find any difference in any of the plans? Is there any one plan that's been interested in contracting with you for specialty services?

DR. HEWETT: No, we have tried several and sometimes I can't believe we haven't been able to get returned phone calls.

MS. DECKER: Thank you, Doctor.

DR. ROMERO: I'm curious is this trend exclusive to managed care or have you seen the interest dwindling in indemnity plans also?

DR. HEWETT: No. I would say indemnity plans follow through. Most of our patients are over 65 so they have Medicare. Medicare, of course, follows and supplementals will pay. We sometimes actively recommend disenrollment and return to Medicare so the patient can get a full diagnostic work up. But we regularly discount

our services.

DR. ROMERO: Two other questions while we're on that subject. Can you give me rough percentage in terms of how much you discount verses your cost?

DR. HEWETT: About 60 percent.

DR. ROMERO: And final question -- sorry, oh, yeah -- pretty apropos. You'll notice I'm within my eight minute office visit though. Do you know if there are other large classes of illness whose treatment centers suffer similarly the way you do, other mental health centers or others?

DR. HEWETT: Yeah.

DR. ROMERO: And here I'm talking strictly within the university funded system not private system.

DR. HEWETT: We're not university funded. We are funded by the State of California. We are funded by taxpayer money the State of California has --

DR. ROMERO: So is the university.

DR. HEWETT: Yes, yes, okay. We have been -- the nine centers developed in the State of California team with 11 centers for caregiver support resource and referral and I think 36 Alzheimer's day care centers. California has been very forthright and forward thinking in developing services for dementia. These services are there and available and will be increasingly needed. National public radio had a report on the aging of the population. In 2020 I will be 74 years old and I will be one of 30 percent of the population to be over 65.

This problem is not going away, and so you know we must address it. Managed care can do this. Managed care doesn't need to send all our patients to diagnosed dementia. It's easily doable but there were cases that had gone undiagnosed, unreferred to the support systems that they need and the complex cases can be referral to us can be a real cost saving to a managed care plan. Once a person begins to fall through the cracks then things fall apart. Repeated emergency room visits, repeated doctors can be costly and can be preserved.

Thank you.

MR. KERR: Any other questions?

I want to thank you for your participation, you've been very helpful in information and helping to make our decision on our report. The meeting of this task force hearing will be closed.

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STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I, Kimberlee R. Miller, CSR 10869, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witnesses and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED THIS day of ,
1997.

Kimberlee R. Miller, CSR #10869